Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOSEPH MUSCAT MD
7401 SOUTH MAIN STREET
HOUSTON TX 77030

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative

Box Number 19

MFDR Tracking Number

M4-10-0232-01

MFDR Date Received

September 11, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received your payment on the claim for the above date of service. However, we are disagreeing with your decision for the fact that as of 3/1/08 the new Medical Fee Guideline were updated. The new Conversion factors are as followed $66.32 [sic] which is for Surgeries performed in a facility (facility Fees=Hospital Setting and after reviewing this claim it was not process as a facility claim [sic]."

Amount in Dispute: $144.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier maintains that the payment amounts made to date are correct for the date of service made the basis of this medical fee dispute. The medical bill(s) made the basis of this Medical Fee Dispute have a contractual discount applied in addition to Fee Guideline reductions."

Response Submitted by: Papas & Suchma, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2009	27385	$144.71	$144.71

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45 (45) – Charges exceed your contracted/legislated fee arrangement
   - 45 (45) – This line was included in the reconsideration of this previously reviewed bill
   - BL – This bill is a reconsideration of a previously reviewed bill
   - BL – Additional allowance is not recommended as this claim was paid in accordance with state guidelines, usual/customary policies, or the...
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation tha...

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the insurance carrier issue payment pursuant to 28 Texas Administrative Code § 134.203(c)?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "45 (45) – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 22, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks additional reimbursement for CPT code 27385 rendered on May 12, 2009. CPT Code 27385 is defined by the AMA CPT Code Book as follows "Suture of quadriceps or hamstring muscle rupture; primary." The requestor submitted documentation to support the billing of CPT code 27385, as a result, reimbursement is recommended pursuant to 28 Texas Administrative Code § 134.203 (c).
3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The requestor provided surgery rendered in a facility setting, therefore the TDI, DWC conversion factor for determining the MAR reimbursement for 2009 is $67.38. The MAR reimbursement for CPT code 27385 is $1,120.03, the insurance carrier issued payment in the amount of $892.30, which leaves a balance of $227.73. The requestor seeks additional reimbursement in the amount of $144.71, therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $144.71.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $144.71 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.